Model 2003 EOC
Medicare Cost Plan Reference Guide

This reference guide is intended to aid Medicare cost plans in the development of their 2003 EOCs. The guide indicates those sections of the 2003 model EOC that need to be changed to accommodate cost plan rules.

- Column 1, "Model EOC Section/Subsection" is based on the sections and subsections contained in the 2003 model EOC.
- Column 2, "Need Change?" indicates whether a change would be needed to the cost plan EOC ("Yes" means a change is necessary).
- Column 3, "If yes, what changes are needed?" outlines what change is needed if Column 2 contains a "Yes."

Note: This Reference Guide does not indicate all places in the model in which reference to "Medicare+Choice" needs to be changed to "Medicare managed care." Medicare cost plans should make changes as needed. Also, cost plans are free to make changes consistent with the guidance provided by CMS in the Attachment (Additional Instructions) to the cover memorandum for the 2003 Model EOC. Cost plans may also revise the language in the Model EOC to reflect accurately their plan's referral requirements.

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Reference Page	No	
Welcome Letter	No	
Table of Contents	Yes	(See specific changes below)
Section 2 Using plan providers to get your covered services		Change to: "Using plan providers to get your services covered by [name of Medicare cost plan]"
Use your plan membership card instead of your red, white and blue Medicare card		Change to: "Use your plan membership card instead of your red, white and blue Medicare card when you visit plan providers or obtain emergency or out-of-area urgently needed care services."
Section 5 If you get services that are not covered, you must pay for them yourself		Revise to indicate that this refers to services that are excluded from coverage, not services that are provided by non-plan providers.
Section 12 Until your membership officially ends, you must keep getting your Medicare services through [name of M+C plan] or you will have to pay for them yourself		Change to: "Until your membership officially ends, your benefits will remain the same -- you must get your Medicare services through [name of Medicare cost plan] or you will have to pay the Original Medicare cost sharing amounts."
You must leave [name of M+C plan] if you move out of the service area or are away from the service area for more than six months in a row		Change title to reflect that individuals must disenroll or will be disenrolled if they move out of the service area or are away from the service area for more than 90 days or another applicable period up to one year if the Medicare cost plan offers an extended absence option.
Section 1: Telephone numbers and other information for reference	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
[[State-specific name of SHIP]/SHIP] – an organization in your state that provides free Medicare help and information	Yes	Change the last two sentences of the first paragraph to the following: "[{State-specific name of SHIP}/Your SHIP] has information about *Medicare managed care plans* and about Medigap (Medicare supplemental insurance). This includes information about special Medigap rights for people who disenroll from a Medicare cost plan under certain circumstances, including people who disenroll from a Medigap plan to enroll in a Medicare cost plan for the first time and wish to return to Medigap within 12 months."
Section 2: Getting the care you need, including some rules you must follow		
Table of Contents	Yes	1. Change "Using plan providers to get your covered services" to "Using plan providers to get your services covered by [name of Medicare cost plan]" 2. Change "Use your plan membership card instead of your red, white and blue Medicare card" to: "Use your plan membership card instead of your red, white and blue Medicare card when you visit plan providers or obtain emergency or out-of-area urgently needed care services"
What is [name of M+C plan]?	Yes	Second paragraph: Modify to indicate that members may receive benefits outside of the health plan network. However, staying within the plan provider network will result in plan benefits, and going outside of the network, except for emergencies, out-of-area urgently needed care, and referrals from a plan provider will result in member responsibility for Original Medicare cost sharing amounts.
Use your plan membership card instead of your red, white and blue Medicare card	Yes	1. Change heading to: "Use your plan membership card instead of your red, white and blue Medicare card when you visit plan providers or obtain emergency or out-of-area urgently needed care services" 2. Replace second paragraph to state "Use your red, white, and blue Medicare card when you want to receive services, other than emergency or out-of-area urgently needed services, from non-plan providers." Note that such services will be subject to cost sharing under the Original Medicare program. 3. If the Medicare cost plan instructs its enrollees to use their Medicare card for all non-network services, the above language can be changed accordingly. Comparable changes can be made throughout the EOC to address this practice.
Help us keep your membership record up to date	No	
What is the geographic service area for [name of M+C plan]	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Using plan providers to get your covered services	Yes	1. Change title to: "Using plan providers to get your services covered by [name of Medicare cost plan]" 2. Change subtitle to: "You will be using plan services to receive full benefits under [name of Medicare cost plan]" 3. Introductory sentence: Modify to indicate that members may also obtain services from non-plan Medicare providers. However, those services will be subject to Original Medicare cost sharing amounts. 4. Last paragraph: Delete the last two sentences.
Choosing your PCP	Yes	What is a PCP: Add a sentence to the end noting that enrollees do not need a referral to see a non-plan provider, however, such services will be subject to Original Medicare cost sharing amounts.
Getting care from your PCP	Yes	Revise the second paragraph, fourth sentence to read as follows: "If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist), *unless you choose to receive the services from non-plan providers and pay the Original Medicare cost sharing amounts.*"
What if you need medical care when your PCP's office is closed?	Yes	1. What to do if it is not an emergency: In the second paragraph, modify the second sentence to read "If you have an urgent need for care while you are in the [name of Medicare cost plan] service area, *you must get this care from plan providers or you must pay the Original Medicare cost sharing amounts.*" 2. Delete the third sentence.
Getting care from specialists	Yes	1. In the second paragraph, first sentence, delete ", including women's health care," Cost plans are not obligated to provide direct access to Pap tests, pelvic and breast exams. Revise the second sentence to read "If you don't have a referral before you receive services from a specialist, we will not cover the service. If Original Medicare will cover the service, you will have to pay the Original Medicare cost sharing amounts." 2. In the final paragraph: Explain that members may go outside of the network but will be obligated to pay Original Medicare cost sharing amounts.

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
There are some services you can get on your own, without a referral	Yes	1. Revise the first paragraph, second sentence to read as follows: "In most situations, if you get services from any doctor, hospital, or other health care provider without getting approval in advance from your PCP, we will not cover the service. If Original Medicare covers the service, you will have to pay the Original Medicare cost sharing amounts." 2. In the bulleted list, Cost plans may change the text to reflect the following: Cost plans only need cover flu shots without a referral, they may delete "pneumococcal vaccinations" in the second bullet. Cost plans only need cover mammograms without a referral, they are permitted to delete "pap tests, pelvic and breast exams" in the first bullet. In the fifth bullet, delete references to the availability of urgently needed services within the service area. 3. Delete the last bullet concerning renal dialysis services.
Getting care when you travel or are away from the service area	Yes	1.Revise to reflect 90-day out of area rule; Member retention for up to one year is permitted - 42 CFR 417.460(f)(2). Medicare cost plan should explain its policy. 2. Explain that going outside of the network for non-routine care, except for emergencies and out-of area urgent care will result in coverage under Original Medicare. 3. Delete any reference to out of area renal dialysis.
Changing doctors	No	
Section 3: Getting care in an emergency or when you have an urgent need for care		

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
What is a medical emergency?	No	
What should you do if you have a medical emergency?	No	
[[Name of M+C plan]/Your PCP/Your medical group] will help manage and follow up on your emergency care	Yes	Revise to reflect that non emergency services are only covered by the Medicare cost plan if they are authorized by the plan or provided by a plan provider. Otherwise, they are covered under Original Medicare.
What is covered if you have a medical emergency?	No	
What if it really wasn't a medical emergency?	Yes	Medicare cost plans are not subject to the "prudent layperson" definition of emergency condition. Delete the last sentence of the first paragraph. In the second bullet point, after the first sentence, note that such care will be covered under Original Medicare
What is "urgently needed care"?	No	
Getting urgently needed care when you are in the plan's service area	Yes	1. Revise the second to last sentence to state that you **must** get care from a plan provider if you are in the service area. Medicare cost plans may note that obtaining urgently needed care from a non-plan provider within the service area will result in coverage under Original Medicare and the enrollee will have to pay the Original Medicare cost sharing amounts. 2. Delete the final sentence.
Getting urgently needed care when you are outside the plan's service area	Yes	Delete second paragraph concerning out of area renal dialysis.
Section 4: Benefits chart		
What are "covered services"?	No	
There are some conditions that apply to getting covered services	Yes	Change the last sentence of the last bulleted paragraph to: "The exceptions are urgently needed care provided when you are temporarily outside of [name of Medicare cost plan]'s service area and emergency care." Add a sentence noting that care provided by non-plan providers without authorization by the Medicare cost plan will be covered under Original Medicare and enrollees will have to pay Original Medicare cost sharing amounts.

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Benefits Chart – a list of the covered services you get as a member of [name of M+C plan]	Yes	1. "Emergency Services" -- Change definition consistent with 42 CFR 417.401. 2. "Outpatient diagnostic and therapeutic services and supplies" – In third bullet, delete phrase in parentheses concerning out of area renal dialysis. 3. "Screening Pap test, screening pelvic exam, and clinical breast exam" – Medicare cost plans are not required to provide direct access. 4. Immunizations – Medicare cost plans are not required to provide direct access to pneumoccocal vaccines. 5. Cost plans may delete all benefit categories that describe non-Medicare covered services, if they are not applicable.
Extra benefits you can buy (these are called "optional supplemental benefits")	Yes	Only include if applicable. Optional supplemental benefits are not subject to the appeals process. Delete the final sentence.
What if you have problems getting services you believe are covered for you?	No	
Can your benefits change during the year?	Yes	Medicare cost plans send notice of changes in November, change date in final sentence of this section to November 2003
Can your prescription drug formulary list change during the year?	No	(If applicable)
Section 5: Medical care and services that are not covered (list of exclusions)		
Table of contents	Yes	Change "If you get services that are not covered, you must pay for them yourself " either to indicate that this refers to services that are excluded from coverage, not services that are provided by non-plan providers or to state, we will not pay for them.
Introduction	No	
If you get services that are not covered, you must pay for them yourself	Yes	Revise this section and heading to note that the Medicare cost plan will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and, unless otherwise noted, neither will Original Medicare.

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
What services are not covered by [name of plan]?	Yes	1. Under the second numbered item , delete the reference to out-of-area renal dialysis. Note that care provided by non-plan providers, without plan authorization, is covered under Original Medicare and enrollees will be obligated to pay original Medicare cost sharing amounts. 2. Under the third and fourth number items, Medicare cost plans may note that services provided without a referral or prior authorization may be covered under Original Medicare if they are medically necessary. 3. Under the sixth numbered item, cost plans may note that emergency facility services for non-authorized routine conditions may be covered under Original Medicare.
Section 6: Prescription drugs	Yes	(If applicable) Member complaints about non-Medicare prescription drug coverage are not appealable. Revise the final paragraph of Section 6 to remove the appeals references.
Section 7: Hospital care, nursing facility care, and other services	Yes	Throughout this chapter, Billing option 1 cost plans may need to modify language wherever appropriate, to be sure it is clear that Medicare (not the plan) would pay for the member's covered stay
Hospital care	Yes	Under "What happens if you join or drop out of [name of M+C plan] during a hospital stay – delete the following words: "special rules apply to your coverage for the stay and to the copayments [coinsurance] you owe for this stay. If this situation applies to you,"
Skilled nursing facility care (SNF care)	Yes	Delete the section titled "In some situations, you may be able to get care in a SNF that is not a plan provider."
Some services you get in the hospital or skilled nursing facility (SNF) may be covered even if your inpatient stay in the hospital or SNF is not covered	Yes	Note that if the stay is not covered by the Medicare cost plan because it is with a non-plan provider, then the services incurred during the stay will also not be covered under the Medicare cost plan. Both may be covered under Original Medicare.
Home health care	No	
Hospice care for people who are terminally ill	No	
Organ transplants	No	
Participating in a clinical trial	No	
Care in religious non-medical health care institutions	No	
Section 8: What you must pay for your Medicare health plan coverage and for the care you receive		

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Table of contents	No	
Paying the premium for your health plan coverage as a member of {plan}	Yes	1. In the first paragraph, remove the reference to being obligated to continue paying the Part A premium in order to continue to be a member. 2. In the discussion concerning what happens if you do not pay your premiums, note that nonpayment of premiums requires the notice of disenrollment date to be 20 days prior to the termination date. Also, remove the references to the 90 grace period for nonpayment of premiums. 3.Under the heading, Can your plan premiums change during the year, modifye the parenthetical stating that we will tell you in October 2003 if there are any changes for the next calendar year by replacing "October 2003" with "November 2003". 4. If applicable, the Medicare cost plan should include in the discussion of nonpayment of premiums the following: If a Medicare cost plan enrollee fails to pay the premium for optional supplemental benefits, the Medicare cost plan must convert the enrollee to the standard benefit package if the premium for the standard benefit package is paid by the enrollee or is 0.
Paying your share of the cost when you get covered services ([deductibles,] co-payments [, and coinsurance])	No	
You must pay the full cost of services that are not covered	Yes	Revise to reflect Original Medicare coverage for services provided by non-plan providers.
Please keep us up-to-date on any other health insurance coverage you have	No	
What should you do if you have bills you think we should pay?	Yes	1. Delete reference to out-of-area renal dialysis services. 2. Change "urgently needed care" to "urgently needed care that you receive when you are temporarily outside of [name of Medicare Cost Plan]'s service area." 3. Modify second paragraph to more clearly state plan's policy with respect to payment for non-contracting providers (Cost plans are permitted to require billing to Original Medicare for non-contracting providers. Cost plans then pay applicable deductibles/copays on member's behalf.)
Section 9: Your rights and responsibilities as a member of [name of M+C plan]	Yes	In the heading, "Your right to make complaints," Medicare cost plans may, but are not required to, include language reflecting disputes concerning optional supplemental benefits.

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Section 10: Appeals and Grievances: what to do if you have problems or complaints		
Introduction	No	
What are appeals and grievances?	Yes	Medicare cost plans should revise to indicate that complaints concerning coverage of any optional supplemental benefits are not subject to appeal, but are subject to the grievance process.
This section tells how to make complaints in different situations	Yes	Medicare cost plans should revise to indicate that complaints concerning coverage of any optional supplemental benefits are not subject to appeal, but are subject to the grievance process.
PART 1. Making complaints (called "appeals") [name of M+CO] to change a decision about what we will cover for you or what we will pay for	Yes	Medicare cost plans should revise to indicate that complaints concerning coverage of any optional supplemental benefits are not subject to appeal, but are subject to the grievance process.
PART 2. Making complaints if you think you are being discharged from the hospital too soon	Yes	For cost plans electing billing option 1 [42 CFR 417.532(c)], language needs to be modified to show that it is the Original Medicare Fiscal Intermediary that is responsible for processing hospital-discharge appeals that are not processed by the QIO. (In other words, for inpatient hospital and SNF appeals, since the cost plan that has elected billing option 1 relies on Original Medicare to pay the claim, it needs to be made clear that any disputes related to that claim payment should be directed to the FI that has responsibility for payment)
Part 3. Making complaints (called "grievances") about any other types of problem you have with [name of M+CO/M+C plan] or one of our plan providers		Medicare cost plans should indicate that complaints about coverage of, or payment for, optional supplemental benefits are subject to the grievance process.
Section 11: Detailed information about how to make an appeal	Yes	General: 1. Modify by substituting any stricter State requirements that do not serve as obstacle to meeting obligations under Federal regulations. 2. Delete references to optional supplemental benefits being subject to appeals rules.
What is the purpose of this section?	No	
What are "complaints about you coverage or payment for your care"?	Yes	Indicate that complaints related to optional supplemental benefits are not included.
How does the appeals process work?	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Step 1- Step 2	Yes	1. Revise to reflect the following Medicare cost plan time frames, which are different from the M+C timeframes: 60-day w/no extensions for standard initial decisions (service and payment); 60-day w/no extensions for standard appeal; 72 hours with up to 10-working day extension allowed for expedited reviews. Medicare cost plan time frames for effectuation dates are based on medical necessity or within 30 days. 2. In the sentence after the bold phrase "Either you, someone you appoint, or your provider may file this appeal" Medicare cost plans may explain that this only applies to covered out-of-plan services, such as emergency or out-of-area urgently needed services. Other out-of-plan services are provided under Original Medicare.
Step 3	Yes	1. Revise to reflect CHDR time frames, which are different: 60-day timeframe for service and payment; 2. Provision of service/payment after overturn: as soon as medically necessary but no later than 30 days.
Step 4	No	
Step 5	No	
Step 6	No	
Section 12: Leaving [name of Plan] and your choices for continuing Medicare after you leave		
Table of contents	Yes	1. Change "Until your membership officially ends, you must keep getting your Medicare services through [name of M+C plan] or you will have to pay for them yourself" to: "Until your membership officially ends, your benefits will remain the same -- you must get your Medicare services through [name of Medicare cost plan] or you will have to pay the Original Medicare cost sharing amounts." 2. Change to the extent applicable "You must leave [name of M+C plan] if you move out of the service area or are away from the service area for more than 6 months in a row" to reflect that individuals must disenroll if they move out of the service area or are away from the service area for more than 90 days or another applicable period up to one year if the Medicare cost plan offers an extended absence option.
What is "disenrollment"?	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Until your membership officially ends, you must keep getting your Medicare services through [name of M+C plan] or you will have to pay for them yourself	Yes	1. Change title to: "Until your membership officially ends, your benefits will remain the same -- you must get your Medicare services through [name of Medicare cost plan] or you will have to pay the Original Medicare cost sharing amounts." 2. Revise the language to reflect that going outside of the plan, except for emergencies and out-of-area urgent care, for care prior to the date of disenrollment will result in coverage under Original Medicare. 3. Delete the reference to out-of-area dialysis and statement that out-of-network services will not be paid for by the plan or Medicare. 4. Delete the sentences concerning hospitalization on day membership terminates.
What are your choices for continuing Medicare if you leave (plan)?	No	
When can you switch among your Medicare choices?	Yes	1. In the second bullet, revise the last sentence to state that *Medicare+Choice* plans must accept new members during open enrollment. 2. Revise final paragraph by deleting the last sentence referring to the disenrollment rules that apply when new elections are made during the annual election period.
What should you do if you decide to leave (plan)	No	
How to change from (plan) to Original Medicare	Yes	1. Medicare cost plan enrollees do not have guaranteed issue in a Medigap policy during a "trial period" unless they were previously enrolled in a Medigap policy. Revise to delete the second trial situation (joined a Medicare health plan upon turning 65). 2. Item #2 - Effective date will be first of the following month after receipt of request, but no later than 3 months after receipt. There is no exception for November. 3. Revise language in item #3 to state that upon disenrollment the former member should use his/her red, white, and blue Medicare card for all services.
How to change from (plan) to another Medicare managed care plan or PFFS	No	
What happens to you if (MCO) leaves the Medicare program or (plan) leaves the area where you live?	Yes	Revise to reflect that Medicare cost plans have 60 days to give notice to members (not 90)

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
You must leave [name of M+C plan] if you move out of the service area or are away from the service area for more than 6 months in a row	Yes	1. Change title to reflect that individuals must disenroll if they move out of the service area or are away from the service area for more than 90 days or another applicable period up to one year if the Medicare cost plan offers an extended absence option. 2. Change reference to 6-month rule to reference to 90-day out of area rule or use other applicable heading if your plan offers an extended absence option. Cost HMOs or CMPs that offer an extended absence option may retain members who *temporarily* (more than 90 days but less than one year) leave the service area by either covering all out-of area routine services for such members or by placing restrictions on services received out of area such as requiring prior authorization or designated providers (e.g., an affiliated organization). 42 FR 417.460(f)(2) and HMO/CMP Manual 2004.4
Under certain conditions (plan) can end your membership and make you leave the plan	Yes	1. Change reference to 6-month rule to reference to 90-day out of area rule (or other rule if plan offers an extended absence option). 2. Member retention for up to one year is permitted under extended absence option - 42 CFR 417.460(f)(2). Cost plan should explain its policy. 3. Bullet 2, delete "both Medicare Part A and" and reference to Part A 4. Bullet 6, nonpayment of premiums requires the notice of disenrollment date be 20 days prior to the termination date. Also, delete reference to 90-day grace period.
You have the right to make a complaint if we ask you to leave (plan)	No	
Section 13 Legal notices	No	
Section 14 Definitions of some words used in this booklet	Yes	1. Insert a definition for "Medicare Cost plan" 2. "Non-plan provider or non-plan facility" – note that services provided by these providers are covered under Original Medicare. 3. Add definition of "Medicare managed care plan" which includes Medicare cost plans and Medicare+Choice plans as defined in this section. 4. Service area – change references from Medicare+Choice to the appropriate Medicare Cost references.